Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDI-PLUS PHARMACY
PO BOX 546
BARKER TX 77413

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LAMAR CISD

Carrier's Austin Representative Box
Box Number 29

MFDR Tracking Number
M4-11-4938-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Reduction of claims due to (CAC-W10) "No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology." – Tristar Managed Care has determined that there is no maximum allowable reimbursement (MAR) for prescription medication and that it can pay a fair and reasonable amount based on its estimation of what is Usual and Customary in the market. Tristar Managed Care has not provided any documentation to date to show how it determined Usual and Customary or what its reported 'research' showed, much less how it determined fair and reasonable. Division Rule 134.503 provides that the MAR is the lesser of the provider's usual and customary charge or the amount determined by a formula provided in 134.503(a)(2)."

Amount in Dispute: $748.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Division received the DWC 60 on August 25, 2011 as evidenced by the date stamp on the face of the document. It is clear that this DWC60 was not timely filed. Requestor has waived their right to Medical Fee Dispute Resolution. The Carrier asks that this Medical Fee Dispute Resolution Dispute be dismissed for lack of jurisdiction."

Response Submitted by: Pappas & Suchma, PC, PO Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2009 February 12, 2009 March 12, 2009 April 4, 2009 June 9, 2009 July 9, 2009 August 6, 2009 September 1, 2009	HYDROCOD/APAP 10/650 TAB	$748.40	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issue

1. Did the requestor timely file the Request for Medical Fee Dispute Resolution in accordance with 28 Texas Administrative Code §133.307?

Findings

1. Per 28 Texas Administrative Code §133.307(c), requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the requests with the Division. (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. The submitted DWC-60 was date stamped on August 25, 2011; the disputed dates of service are January 15, 2009 through September 1, 2009. The Requestor did not filed the request within one year after the dates of service in dispute and therefore, this dispute is not eligible for review.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature — Medical Fee Dispute Resolution Officer — Date: 1/9/11

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.